PRESBYTERIAN

EMPLOYEE ACTION FORM

Presbyterian Health Plan, Inc.
Presbyterian Insurance Company, Inc.

Employer Information

Employer:	Sub-group / Department:	Group Number:
Safe Site Educational Center		

Section A: Type of Action

☐ New Enrollment or Qualifying Event:		☐ Waive Coverage *(complete Section A, sign and date)*	☐ Terminate Coverage
☐ Open/New Enrollment	☐ New Hire	☐ Other Coverage	Date:
☐ Qualifying Event	☐ Newborn	☐ Individual ☐ Medicare ☐ Medicaid	Reason:
Date of Event:	☐ Marriage	☐ Other Employer: _____	
	☐ Court Order	☐ Selecting no coverage	

Presbyterian plan selected if more than one plan is offered by employer: HMO Platinum 1 (plan selected)

☒ Single ☐ Two-party ☐ EE + Child(ren) ☐ Family (coverage selected)

Section B: Employee Information

Employee Last Name:	Employee First Name & MI:	Date of Birth:	Phone #'s:	Social Security #:
Guzman	Lissa	1-9-71	Wk.: ( ) 505 306 7265 Hm./Cell: ( )	[redacted]

Mailing Address:	City:	State:	Zip:	Email Address:
10617 Pennyback Park Dr NE	Alb	NM	87123	lissaaguzman@yahoo.com

Employment Status:	Date of Hire:	Occupation:	Gender:	Ethnicity (optional):	Other Language/ Disability Needs:
☒ Fulltime ☐ Part-time Hours per wk: Salary		HR	F	Hispanic	NONE

Section C: Dependent Information

Dep. Type:	Last Name:	First Name &MI:	Social Security #:	Gender:	Date of Birth:	Eff. Date:	Primary Care:	Court order?
Spouse								
Child								
Child								
Child								
Child								

Section D: Other Medical Benefits For Coordination (if applicable)

Family Member Name(s):	☐ Private Insurance: _____	☐ Medicare #: _____	☐ Not applicable

Section E: Consent / Signatures

You must read all pages of this application. By signing this application you agree you have read all pages and agree that all information is correct and you have authority to act on behalf of and fully bind all of the dependents with respect to every provision of the Group Subscriber Agreement.

Employee Signature:		Date Signed:	8/2/17

MPC011731 4/2017

DELTA DENTAL

Dental Benefits Enrollment/Coverage Status Form

Please email an electronic copy of your completed form to groupadmin@deltadentalnm.com

Part A – Employee/Employer Information

Employee Name (last, first, middle initial): Guzman, Lissa	Gender: M ☐ F ☒	Married? Y ☐ N ☐	Social Security Number: [redacted]	Date of Birth (mm/dd/yy): 01/09/1971
Name of Employer: Safe Site	Group Number		Employee's Work Site Location/Branch: Los Lunas	Date of Hire (mm/dd/yy): __/__/2013
Employee Position/Title: HR			Do you have other dental benefits? Y ☐ N ☐ Name of other plan, if applicable: ________	
Home Mailing Address (including city, state, ZIP Code): 10617 Pennybach Park Dr NE ABQ NM 87123				☐ Check here if new address

Part B – Enrollment or Other Action Required

☒ Enroll in Dental Plan

Enrollee Category

☒ Active Employee
☐ Retiree
☐ COBRA

Network Selection, if applicable to your plan: ________

☐ Waive Coverage: Please complete and sign Part F below.

☐ Cancel Employee Coverage (also cancels dependent coverage, if applicable)
☐ Add Dependents (list new dependents to be covered in Part C)
☐ Cancel Dependent Coverage
☐ On all dependents currently enrolled
☐ On dependent(s) listed here: ________

Coverage Effective/Change/Coverage Termination Date 09/01/17 Reason for Action (At least one box must be checked. Check all that apply.):

☒ New Hire
☒ Initial or Open Enrollment
☐ Change of Status Date: ________
☐ Marriage Date: ________
☐ Divorce Date: ________

☐ Birth ☐ Adoption Date: ________
☐ Termination of Employment Date: ________
☐ Loss of Eligibility due to: ☐ Retirement ☐ Age
☐ Other Loss of Eligibility: ________
☐ Submit Supporting Documentation of Qualifying Event

☐ Death Date: ________
☐ Change of Address
☐ Other: ________

Part C – Dependent Information (For additional dependents, please attach a separate sheet.)

Dependent to be enrolled (last, first, middle initial)	Gender M ☐ F ☐	Social Security Number ___-__-____	Date of Birth (mm/dd/yy) __/__/__
	Relationship	Does he/she have other dental benefits? Y ☐ N ☐ Name of other plan, if applicable: ________	
Dependent to be enrolled (last, first, middle initial)	Gender M ☐ F ☐	Social Security Number ___-__-____	Date of Birth (mm/dd/yy) __/__/__
	Relationship	Does he/she have other dental benefits? Y ☐ N ☐ Name of other plan, if applicable: ________	
Dependent to be enrolled (last, first, middle initial)	Gender M ☐ F ☐	Social Security Number ___-__-____	Date of Birth (mm/dd/yy) __/__/__
	Relationship	Does he/she have other dental benefits? Y ☐ N ☐ Name of other plan, if applicable: ________	
Dependent to be enrolled (last, first, middle initial)	Gender M ☐ F ☐	Social Security Number ___-__-____	Date of Birth (mm/dd/yy) __/__/__
	Relationship	Does he/she have other dental benefits? Y ☐ N ☐ Name of other plan, if applicable: ________	

Part D – Signature for Enrollment and Change of Status

If enrolled, I agree to make the required contribution as stated in the Group contract and to repay promptly any benefit payments to which I or my dependents were not entitled. I certify that the information contained in this form is true and correct to the best of my knowledge. **Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.**

Signature [signature] Date 8/10/17

Part E – For Delta Dental Use Only

Group Number ________ Effective Date of Enrollment and/or Change ________ Termination Date ________

PART F – Waiver of Coverage: Sign here only if you are waiving Delta Dental coverage.

I hereby decline coverage because: ☐ I have other dental coverage. If other coverage, who is your current carrier? ________

☐ Other reason for waiver: ________

I understand that future enrollment of myself or my dependent(s) is subject to the eligibility requirements of my employer's dental plan. **Please check with your Group Administrator to see if your plan allows for a future Open Enrollment period.**

Signature ________ Date ________

This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate that you have health insurance coverage. If you do not have other health insurance coverage, you may be subject to a federal tax penalty.

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